APPENDIX 1c
AMBULANCE - NONMERGENCY, ONE ROUND TRIP WITH ONE MEDICAL FACILITY DESTINATION

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) A (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) (SSN or ID) ( ) (SSN) ( ) (ID)			1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M ( ) F (X)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Recipient, Ima A.			
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)
609 Willow St.	Self ( ) Spouse ( ) Child ( ) Other ( )		
CITY / STATE	8. PATIENT STATUS		CITY / STATE
Anytown WI	Single ( ) Married ( ) Other ( )		
ZIP CODE / TELEPHONE (Include Area Code)	Employed ( ) Full-Time Student ( ) Part-Time Student ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
555555 (XXX)XXX-XXXX			( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
OI-D			
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO ( )		a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ( ) F ( )
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ( ) F ( )	b. AUTO ACCIDENT? YES ( ) NO ( ) PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ( ) NO ( )		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
I.M. Referring Provider	A12345	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V920 2. ____ 3. ____ 4. ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 MM DD YY	2	9	A0150		1	XX XX	1				
2 MM DD YY	2	9	W9072		1	XX XX	20				
3 MM DD YY	2	9	A0060		1	XX XX	1				
4 MM DD YY	7	9	W9072		1	XX XX	20				
5											
6											spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ( ) NO ( )	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
( ) ( )	1234JED		$ XXX XX	$ 0.0	$ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I.M. Authorized	11223344	I.M. Billing 1 W. Williams Anytown, WI 55555 76543218
SIGNED MM/DD/YY DATE		PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500